MEDPAC Medicare Payment Advisory Commission

601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
Website: www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

Medicare payment to physicians for professional liability insurance

The purpose of this document is to describe how Medicare's payment system for physicians takes into account the costs of professional liability insurance.

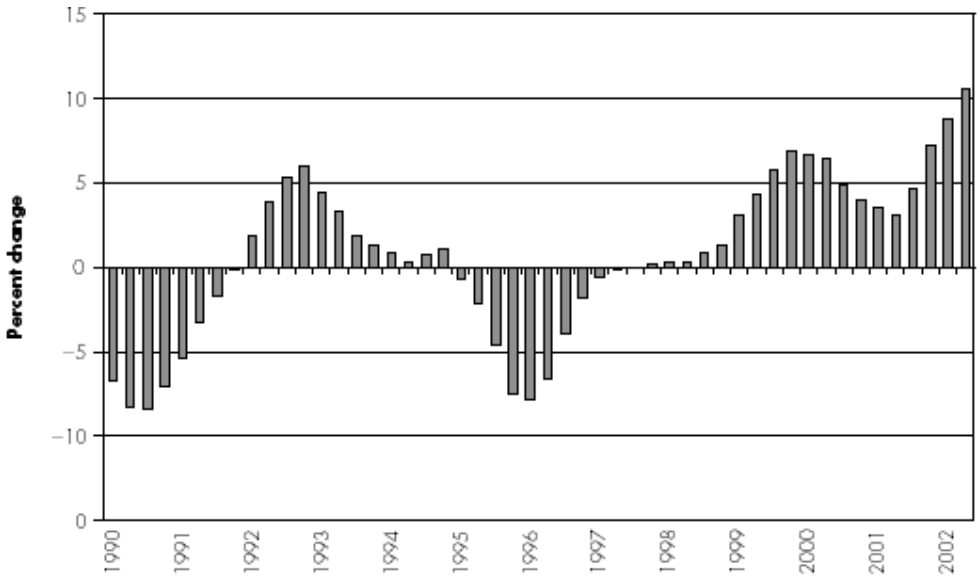
Physicians' professional liability insurance (PLI) premiums have been rising, dramatically for some specialties in some areas of the country. While PLI costs are a small share of total physician revenues, Medicare's payment system for physicians is designed to reflect:

- differences in PLI costs among services and geographic areas and
- national increases in PLI premiums.

Trends in private liability insurance

Historically, changes in premiums for PLI have followed a cyclical pattern, but in 2001 through 2002, premiums did not drop in the way that past experience would have predicted.

Quarterly estimates of annual changes in professional liability insurance premiums, 1990-2002



Source: Unpublished CMS data.

The increase in PLI premiums in 2002 was the highest in over a decade, at 11.3 percent. Several factors may have played a role in the current rise in premiums, which is more pronounced in certain markets. In some states, the strong economy in the 1990s prompted insurers to enter new markets. Typically, new entry in insurance markets is marked by a period of low premiums (to gain market share), then higher premiums to build reserves, which may be what is happening now. At the same time, there are reports that the size of jury awards in malpractice cases rose. Increases in awards together with lower investment returns from financial markets could have led some insurers to adopt more conservative business strategies, including exiting some markets and raising premiums, with particularly large effects in some areas of the country.

PLI insurance and Medicare's physician fee schedule

Medicare uses information on PLI premium costs to redistribute funds among specialties, services, and areas and to increase payments to reflect overall cost increases. The fee schedule calculation changes the distribution of payments among services and geographic areas to reflect changes in the distribution of PLI premiums within a fixed pool of dollars. The update formula accounts for changes in the cost of providing services.

The fee schedule calculation

The fee schedule sets the level of payments for a given service and geographic area. Medicare pays physicians using a fee schedule for more than 7,000 services.

RVUs—Each service has three weights—called relative value units (RVUs)—that measure the relative costliness of three types of resources used to provide different physician services: physician work, practice expenses, and expenses for PLI. RVUs measure cost differences by type of service, regardless of geographic area. Although data are collected on a specialty basis, they are mapped to specific services based on each specialty's share of the total use of the service and the services' work RVUs.

GPCIs—Payments vary among the 89 geographic fee schedule areas to the extent that the costs of providing services differ. This variation in the costs for work, practice expense, and PLI is measured using geographic practice cost indexes (GPCIs). GPCIs measure cost differences by geographic area, regardless of service. The PLI GPCI reflects the average premium in an area relative to the national average premium.

The three RVUs, the GPCIs, and the conversion factor combine to calculate the rate for a given service.

Calculating 2003 physician payments: an illustration

The payment rate for an office visit (in West Virginia) is:

Work RVU x work GPCI (0.67 x 0.963) +
Practice expense RVU x practice expense GPCI (0.69 x 0.850) +
PLI RVU x PLI GPCI (0.03 x 1.378)

x conversion factor in 2003 ($36.79)
= payment rate ($46.84)

The GPCI for PLI of 1.378 shows that the relative cost of PLI in West Virginia is around 38 percent higher than the national average.

CMS uses new data to revise the RVUs and GPCIs according to a schedule specified in law—every five years for RVUs and every three years for GPCIs. The agency will next revise the PLI RVUs in 2006 and the GPCIs in 2004.

These revisions are budget neutral but can redistribute payments among services (in the case of RVUs) or among geographic areas (in the case of GPCIs).

The update and the Medicare Economic Index

Changes in the input prices for physician services are measured using the Medicare Economic Index (MEI), a weighted measure of average national prices for inputs needed to produce physicians' services (such as employee wages, rents, and PLI premiums). The index measures changes in prices each year, based on data from a variety of sources.

PLI premiums contribute 3.2 percent to the total index, so even large changes in national premiums have a relatively small effect on the MEI. For example, if PLI premiums rose nationally by an average of 4.6 percent, as was forecast for 2003, and the cost of no other components rose, the MEI would rise by 3.2 percent of 4.6 percent, or 0.147 percentage points. Data on PLI premiums come from a survey of major insurers conducted by CMS. The component weights of the MEI are reviewed every five to six years, but there is not a set schedule. If PLI costs were to increase substantially more than costs for other components, the portion of the MEI represented by these costs would increase. From 1990 through 1998, PLI premiums remained in a narrow range, from 3 to 5 percent of revenues.

Even though the update formula provides for additional payments for PLI through the MEI, updates are limited if growth in the volume of physician services exceeds a target rate of growth. Until recently, Medicare's payments have generally increased at the rate of the MEI.

Age of the data and stability of estimates

For both the RVUs and GPCIs, CMS generally needs about three years to collect and analyze data, publish a notice of proposed rulemaking, respond to questions, and publish a new rule.

Given this time lag, the schedule for revising the RVUs and GPCIs, and a PLI market that is usually cyclical, CMS uses multiple years of data to make the revisions. Averaging these data produces stable estimates, which reduce the possibility of payments that are distorted by anomalies in the data, transitory changes in PLI premiums, or unusual conditions in local markets.

CMS recently announced in its 2003 notice of proposed rulemaking that it will be taking steps to use more recent data for the PLI GPCI.

Staff contact

Kevin Hayes
(202) 220-3700

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